

135571

1- FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

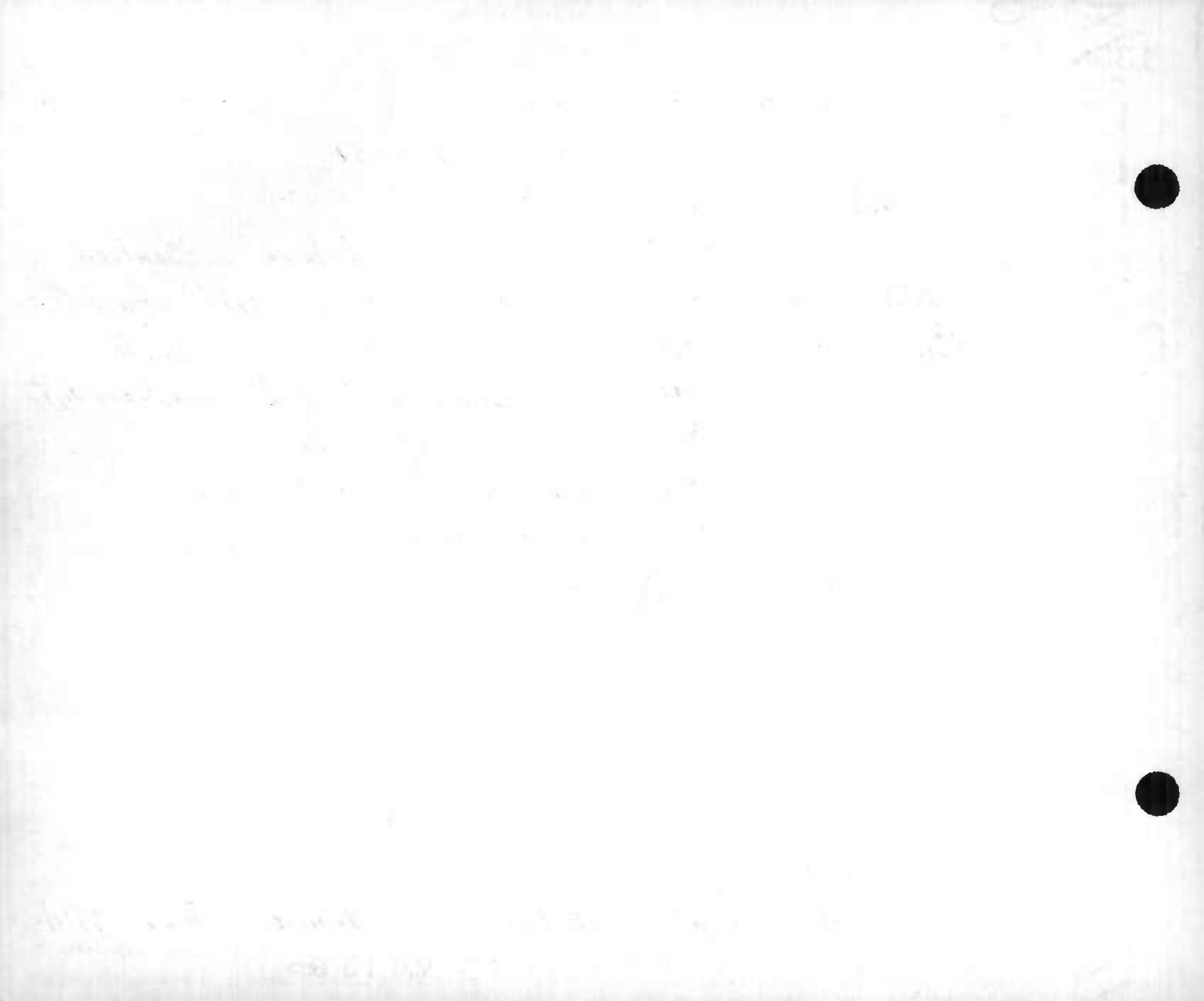
15421

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST Marguerite G. Ames			2a. DATE OF DEATH MONTH DAY YEAR 5-3-85		2b. HOUR 1:15^a M
3. SEX Female	4. RACE Black	5. DATE OF BIRTH MONTH DAY YEAR 9 21 1933		6. AGE (IN YEARS LAST BIRTHDAY) 51 YRS. MONTHS DAYS IF UNDER 1 YEAR IF UNDER 24 HRS.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Md	7b. CITIZEN OF WHAT COUNTRY? USA	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Somerset MD.	
10. CITY OR TOWN OF DEATH Crisfield	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (DO NOT INscribe FACTORY, GIVE STREET ADDRESS) Edw. W. McCready Mem. Hospital		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Laborer		12b. KIND OF BUSINESS OR INDUSTRY Sea Food
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)					
13a. STATE Md	13b. COUNTY Som.	13c. CITY OR TOWN Crisfield	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	13e. STREET ADDRESS / ZIP CODE P.O. Box 748 Crisfield Md. 21817	
14. FATHER'S NAME FIRST MIDDLE LAST CLARENCE Smith		15. MOTHER'S MAIDEN NAME FIRST MIDDLE Gertrude Smith			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) No		16b. SOCIAL SECURITY NO. 217-27-2543		17. INFORMANT ADDRESS Marguerite Fosque - Somers Cove Apt 38	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardio Pulmonary Arrest DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last: (b) Atherosclerotic Heart Disease DUE TO, OR AS A CONSEQUENCE OF (c) Diabetes Mellitus					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a): Carcinoma of the cervix					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) lost saw the deceased alive on _____, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE Jesus Evangelista		DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Dr. Jesus Evangelista		22e. ADDRESS McCready Hospital, Crisfield, Md. 21817			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial	23b. DATE 5/7/85	23c. NAME OF CEMETERY OR CREMATORY Mt. Peer	23d. LOCATION CITY OR TOWN COUNTY STATE Marion Som. Md.		
24. FUNERAL DIRECTOR NAME ADDRESS Anthony Ward, Cove St., Crisfield, Md. 21817			25a. DATE REC'D. BY REGISTRAR MAY 13 1985		

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, pages 1 and 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.



148089

1- FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH15422
REG. NO.

1. DECEASED NAME (TYPE OR PRINT) RUTH J. CLARY			2a. DATE OF DEATH MONTH DAY YEAR 5/17/85			2b. HOUR 1205 P M					
3. SEX Female		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR 9 30 1989		6. AGE (IN YEARS LAST BIRTHDAY) 85 YRS		7. IF UNDER 1 YEAR MONTHS DAYS		8. IF UNDER 24 HRS HOURS MIN.	
9. BIRTHPLACE COUNTRY N. CAROLINA		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH PRINCESS ANNE SOMERSET CO., MD.					
10. CITY OR TOWN OF DEATH PRINCESS ANNE		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) MANOKIN MANOR				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) HOUSEWIFE			12b. KIND OF BUSINESS OR INDUSTRY		
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13b. STATE MD						13c. CITY OR TOWN SALISBURY		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
14. FATHER'S NAME FIRST MIDDLE LAST Fletcher W. Lyles						15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Mary Elizabeth Blackstone					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No				16b. SOCIAL SECURITY NO. Ne		17. INFORMANT ADDRESS 26749-71910 Den Janet, 52156 way, MD					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Respiratory arrest</u> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) <u>Extensive cerebrovascular accident</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>Atherosclerotic cardiovascular disease</u>										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1:											
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)						
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE						
22a. I certify that (I) (this hospital) attended the deceased from <u>April 19</u> , 19 <u>85</u> , to <u>17 May</u> , 19 <u>85</u> , that (we) last saw the deceased alive on <u>17 May 85</u> , 19 <u>85</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE <u>William A Godfrey</u>					DEGREE MD ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL STAFF PHYSICIAN <input type="checkbox"/> DIRECTOR <input type="checkbox"/>					22c. DATE SIGNED May 17 85	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) William A Godfrey					22e. ADDRESS P.O. Box 40 Mt Vernon Rd Princess Anne, MD 21853						
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial			23b. DATE 5/20/85		23c. NAME OF CEMETERY OR CREMATORY Spring Hill M. Gardens			23d. LOCATION CITY OR TOWN COUNTY STATE Salisbury, MD			
24. FUNERAL DIRECTOR NAME C. Vossick, Biville, MD					25. DATE REC'D. BY REGISTRAR MAY 23 1985						

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 1 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1 5 4 2 3

FOR
1. STATE
REGISTRAR

137014

1. DECEASED NAME (TYPE OR PRINT) Alexander Horton			2a. DATE OF DEATH MONTH DAY YEAR 5 2 85			2b. HOUR 30 P M	
3. SEX M	4. RACE B	5. DATE OF BIRTH MONTH DAY YEAR 6 19 05	6. AGE (IN YEARS LAST BIRTHDAY) 79 YRS			7. IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Unknown	7b. CITIZEN OF WHAT COUNTRY? USA	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	9. BALTIMORE CITY OR COUNTY OF DEATH Somerset Co. MD.				
10. CITY OR TOWN OF DEATH Princess Anne		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) MANOR MANOR			12a. USUAL OCCUPATION (TYPE OF WORK OR MOST PREVIOUS WORKING LIFE) Retired		12b. KIND OF BUSINESS OR INDUSTRY

13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE MD		13b. COUNTY Worcester	13c. CITY OR TOWN Horton	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	13e. STREET ADDRESS / ZIP CODE 1210 Market St. 21851
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14. FATHER'S NAME FIRST MIDDLE LAST JOSEPH HORTON	15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST MUMFORD
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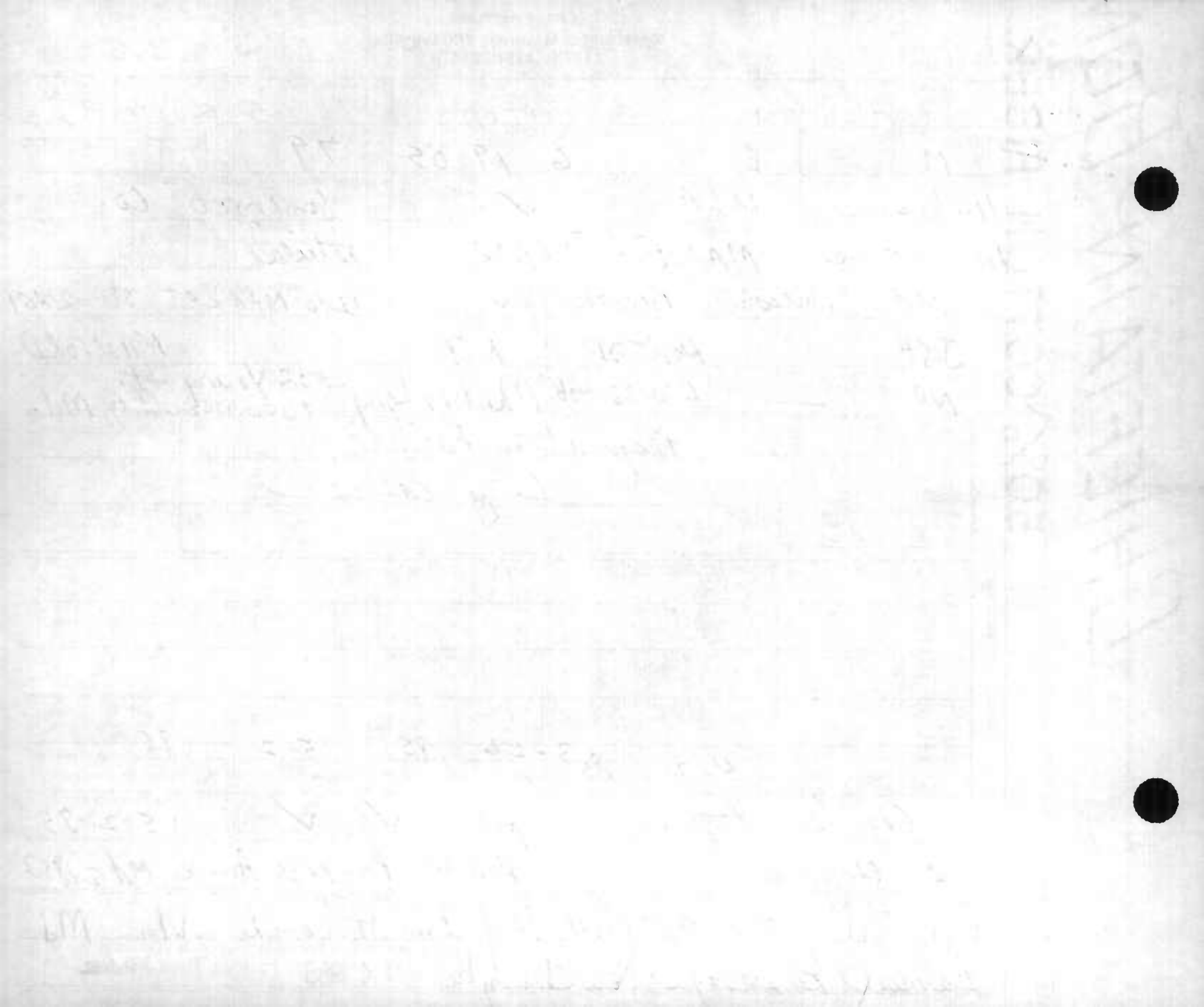
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO	16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 430-22-4064	17. INFORMANT ADDRESS Madora Long 505 Young St. Pocomoke City, Md.
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18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Respiratory Failure</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>Lung Cancer</u> DUE TO, OR AS A CONSEQUENCE OF (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
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PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: _____

19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK	21e. PLACE OF INJURY (AT HOME STREET FACTORY OFFICE FARM ETC.)	21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from <u>3-26</u> 19 <u>85</u> , to <u>5-2</u> 19 <u>85</u> , that (I) (we) lost saw the deceased alive on <u>4-2</u> 19 <u>85</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE Charles Stegman		DEGREE MD		22c. DATE SIGNED 5-2-85	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) C Stegman		22e. ADDRESS POB 40 Princess Anne, Md 21853			

23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial	23b. DATE 5-5-85	23c. NAME OF CEMETERY OR CREMATORY Halls Hill Cem.	23d. LOCATION CITY OR TOWN COUNTY STATE Pocomoke Wor. Md.
24. FUNERAL DIRECTOR NAME Samuel G. Savage		25a. DATE REC'D. BY REGISTRAR MAY 14 1985	
25b. REGISTRAR'S SIGNATURE John Davidson			



158045

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, pages 1 and 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the funeral director's office with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 22 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP

DHMH - 16 50M 4/82
(VRA 15, 4)

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1 5 4 2 4

1. FOR
STATE
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT) Etta Kelly			2a. DATE OF DEATH MONTH DAY YEAR May 28, 1985			2b. HOUR M				
3. SEX F		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR Jan 13 1912		6. AGE (IN YEARS LAST BIRTHDAY) 73 YRS.		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Md		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Somerset MD.				
10. CITY OR TOWN OF DEATH Dames Quarter		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Homemaker		12b. KIND OF BUSINESS OR INDUSTRY		
13a. STATE Md			13b. COUNTY Somerset			13c. CITY OR TOWN Dames Qtr.			13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
14. FATHER'S NAME FIRST MIDDLE LAST Isaac Shores			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Fannie R Dize			13e. STREET ADDRESS 21820				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) no		16b. SOCIAL SECURITY NO. 214-24-8817		17. INFORMANT ADDRESS Dorothy K. Dize - Onancock VA 23417						

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART 1. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a) **Metastatic carcinoma of stomach**

DUE TO, OR AS A CONSEQUENCE OF

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

(b) _____
DUE TO, OR AS A CONSEQUENCE OF

(c) _____

APPROXIMATE INTERVAL
BETWEEN ONSET AND DEATH**2 years**

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)

MEDICAL CERTIFICATION

19a. DATE OF OPERATION Aug 1984		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED Carcinoma of stomach		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE 10-13-58			
22a. I certify that (I) (this hospital) attended the deceased from 10-13-58 , 19____, to 5-28-85 , 19____, that (I) (we) lost saw the deceased alive on 1-2-85 , 19____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE Garrett S. Suter M.D.						22c. DATE SIGNED 5-30-85	
22d. PHYSICIAN'S NAME (TYPE OR PRINT)				22e. ADDRESS Dames Quarter Md 21820			

23a. BURIAL, CREMATION, REMOVAL (SPECIFY) burial		23b. DATE 6/1/85		23c. NAME OF CEMETERY OR CREMATORY Ford Cemetery		23d. LOCATION CITY OR TOWN COUNTY STATE Dames Qtr Som Md	
24. FUNERAL DIRECTOR NAME Leroy G. Webster				24b. ADDRESS Rt. 3, Bx 354 Princess Anne, Md.		25a. DATE REC'D. BY REGISTRAR JUN 5 1985	
25b. REGISTRAR'S SIGNATURE John Davidson-Randall							

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134517

1- FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH15425
REG. NO.

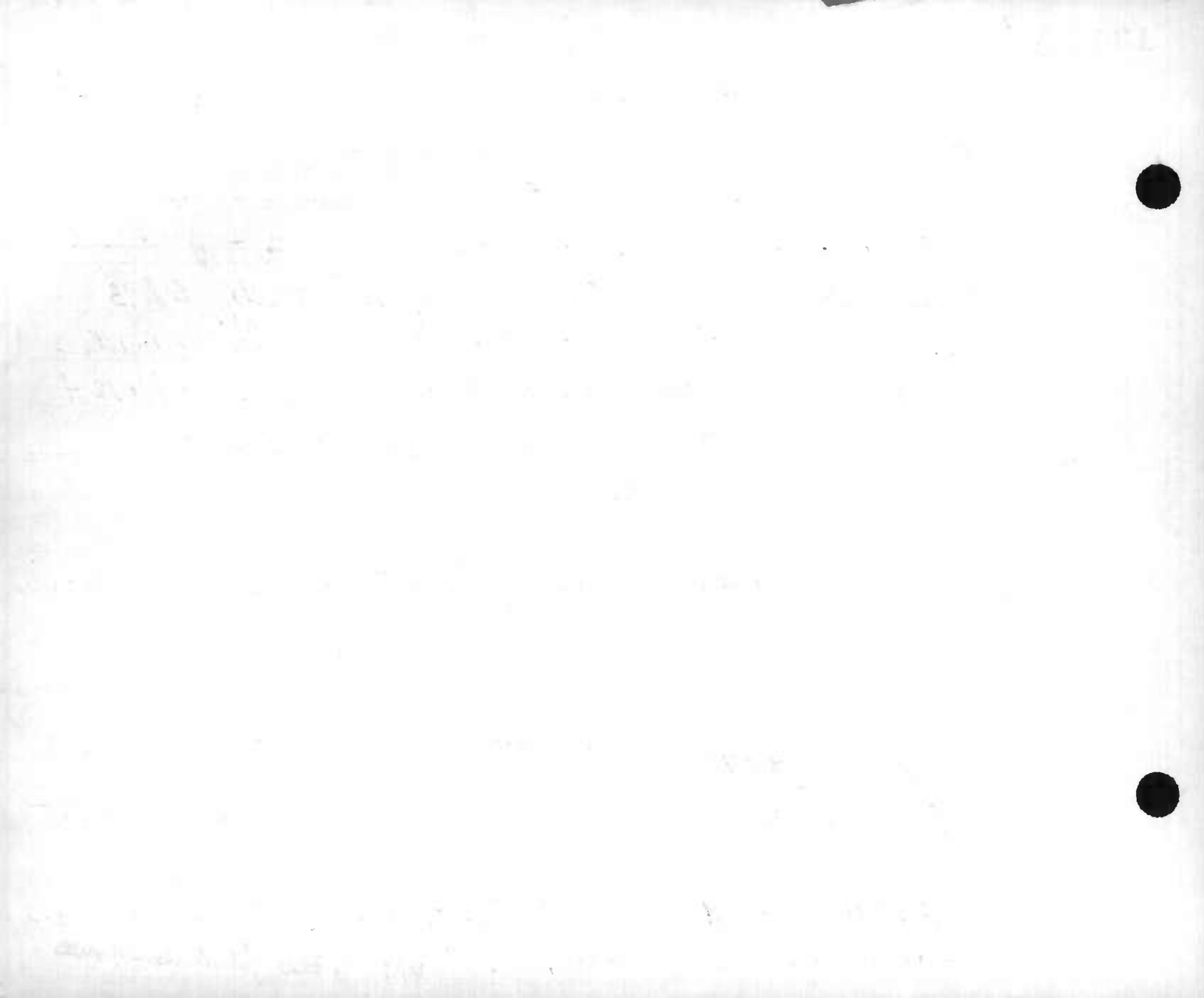
1. DECEASED NAME (TYPE OR PRINT)		FIRST EDNA	MIDDLE Mae	LAST JOHNSON	2a. DATE OF DEATH		MONTH 5	DAY 7	YEAR 85	2b. HOUR 2:05 A.M.	
3. SEX Female		4. RACE Black		5. DATE OF BIRTH		6. AGE (IN YEARS LAST BIRTHDAY)		IF UNDER 1 YEAR MONTHS		IF UNDER 24 HRS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) MD		7b. CITIZEN OF WHAT COUNTRY? U.S.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Somerset County MD.					
10. CITY OR TOWN OF DEATH Crisfield, Md.		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) McCready Memorial Hospital				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING YEARS) Sewing factory		12b. KIND OF BUSINESS OR INDUSTRY			
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13b. COUNTY MD Somerset		13c. CITY OR TOWN Lower Hill		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE Westover St. Box 93					
14. FATHER'S NAME 14a. FIRST Shout		14b. MIDDLE Milbourne		15. MOTHER'S MAIDEN NAME 15a. FIRST Mariah		15b. MIDDLE Milbourne		15c. LAST			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No.		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 219-03-5896		16c. INFORMANT'S NAME John Johnson		16d. ADDRESS Somers No 12A					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Anticerebral hemorrhage on infant</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>ASCD</u> DUE TO, OR AS A CONSEQUENCE OF (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.											
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a) <u>1 Lung abscess 2 Acute Pyelonephritis 3 Sepsis 4 Severe anemia</u>											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOMY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2)							
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE							
22a. I certify that (I) (this hospital) attended the deceased from <u>4/10/85</u> 19____, to <u>5/7/85</u> 19____, that (I) (we) last saw the deceased alive on <u>5/07/85</u> 19____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE <u>J. Davidson</u>				DEGREE				22c. DATE SIGNED <u>5/7/85</u>		ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT)				22e. ADDRESS							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>		23b. DATE <u>May 11, 1985</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Catholic Cemetery</u>		23d. LOCATION CITY OR TOWN COUNTY STATE <u>Lower Hill Somerset MD.</u>					
24. FUNERAL DIRECTOR NAME Ward's Funeral Home				24b. ADDRESS 21838 Marion, Md.		24c. DATE REC'D. BY REGISTRAR MAY 9 1985		24d. REGISTRAR'S SIGNATURE <u>Julia Davidson-Randall</u>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP



148087

1- FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

15426

1. DECEASED NAME (TYPE OR PRINT) Byron Hobart Smith, Jr.			2a. DATE OF DEATH MONTH DAY YEAR 5-20-85			2b. HOUR 6:00am					
3. SEX Male		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR March 28, 1907		6. AGE (IN YEARS LAST BIRTHDAY) 78 YRS.		7. IF UNDER 1 YEAR MONTHS DAYS		8. IF UNDER 24 HRS. HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Massachusetts		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Somerset MD.					
10. CITY OR TOWN OF DEATH Crisfield		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Edw. W. McCready Mem. Hospital				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Pharmacist		12b. KIND OF BUSINESS OR INDUSTRY Pharmaceutical			
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)											
13a. STATE Maryland		13b. COUNTY Somerset		13c. CITY OR TOWN Crisfield		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE 311 Chesapeake Ave. (21817)			
14. FATHER'S NAME FIRST MIDDLE LAST UNKNOWN				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST UNKNOWN							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) no		16b. SOCIAL SECURITY NO. (# YES, GIVE WAR OR DATES) none		17. INFORMANT Rural Route 688 - Box 7 Irene Poulson Mears, Virginia 23409							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Carcinoma Esophagus</u> DUE TO, OR AS A CONSEQUENCE OF (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 1 1/2 yr	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)											
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)						
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE						
22a. I certify that (I) (this hospital) attended the deceased from above, (I) (we) (did) (did not) view the body after death. 5/19/85 5/20/85 19											
22b. SIGNATURE M.D. Barhan					DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>					22c. DATE SIGNED 5/20/85	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Dr. M.D. Barhan					22e. ADDRESS Rt. #413, Crisfield, Md. 21817						
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Cremation			23b. DATE 5/20/85		23c. NAME OF CEMETERY OR CREMATORY Salisbury Crematory			23d. LOCATION CITY OR TOWN COUNTY STATE Salisbury Wicomico Md.			
24. FUNERAL DIRECTOR NAME Bradshaw & Sons, Main St., Crisfield, Md.					25a. DATE REC'D. BY REGISTRAR MAY 23 1985						
					25b. REGISTRAR'S SIGNATURE John Barhan Randall						

MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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1- FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

15427

1. DECEASED NAME (TYPE OR PRINT) Arlie H. Ward			2a. DATE OF DEATH MONTH DAY YEAR 5-31-85			2b. HOUR 4:15aM			
3. SEX Male		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR 12 23 1915		6. AGE (IN YEARS LAST BIRTHDAY) 69 YRS.		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Somerset MD.			
10. CITY OR TOWN OF DEATH Crisfield		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Edw. W. McCready Mem. Hospital				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Proprietor		12b. KIND OF BUSINESS OR INDUSTRY General Store	
13a. STATE MD			13b. COUNTY Somerset		13c. CITY OR TOWN Crisfield		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
14. FATHER'S NAME FIRST MIDDLE LAST Grover Cleveland Ward			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Alva Sterling			16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) Yes WW II			
16b. SOCIAL SECURITY NO. 217-07-2975			17. INFORMANT ADDRESS Fred Ward - 217 Bradford St. - Seaford, DE 19973						
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Carcinoma of Prostate Gland DUE TO, OR AS A CONSEQUENCE OF (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ CONDITIONS, IF ANY, WHICH GAVE RISE TO IMMEDIATE CAUSE (a), stating the underlying cause last.									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 1 Year
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I: (a) Diabetes Mellitus									
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR 5/30 1985		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2) 4				
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE Main St., Crisfield, Md. 21817				
22a. I certify that (1) this hospital attended the deceased from 5/30 19 85 , and that in my (our) opinion death occurred on the date and hour and from the causes stated above (b) and (c) (did not view the body after death).									
22b. SIGNATURE James H. Sterling, M.D. DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>						22c. DATE SIGNED 5/31/85			
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Dr. James Sterling						22e. ADDRESS Main St., Crisfield, Md. 21817			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial			23b. DATE 6/3/85		23c. NAME OF CEMETERY OR CREMATORY American Legion Cemetery/Crisfield-Somerset - MD		23d. LOCATION CITY OR TOWN COUNTY STATE		
24. FUNERAL DIRECTOR NAME Bradshaw & Sons, Crisfield, Md. 21817						25a. DATE REC'D. BY REGISTRAR JUN 4 1985		25b. REGISTRAR'S SIGNATURE	

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MEDICAL CERTIFICATION

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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